Reset Form

ucare

INPATIENT NOTIFICATION FORM

ONLY USE THIS FORM IF NOT ENROLLED IN ENCOUNTER ALERT SYSTEM (EAS)

FYI: ***Incomplete, illegible, or inaccurate forms will be returned to the sender.*** Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request. Review our provider manual criteria references.

☐ **Medical Services**	☐ **Mental Health and Substance Use Disorder Services**
Fax form and relevant clinical documentation to: 612-884-2499 or 1-866-610-7215	Fax form and relevant clinical documentation to: 612-884-2033 or 1-855-260-9710
For questions, call: 612-676-3300 or 1-888-531-1493	For questions, call: 612-676-6533 or 1-833-276-1185
Email: HCM_Fax@ucare.org	Email: MHSUDservices@ucare.org

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	
Member Health Plan (required)*:		

ORDERING PRACTITIONER INFORMATION:		
Ordering Practitioner Name:	Facility NPI Number:	
Facility Name:		
Ordering Practitioner Address:		
City:	State:	Zip Code:
Phone:	Fax:	

FACILITY INFORMATION:		
Facility Name:		
Facility Location Name (required)*:		
Facility Location NPI Number (required)*:		
Facility Location Address:		
City:	State:	Zip Code:

REQUESTOR INFORMATION:	
Request Sent By (Name):	
Phone:	Fax:
Email:	Total Pages Faxed:

TYPE OF ADMISSION: (send discharge summary when applicable)

☐ Inpatient Medical Admission
☐ Inpatient Mental Health Admission
☐ Inpatient Substance Use Disorder (SUD) Admission

ADMISSION DETAILS:	
Admitting Diagnosis:	ICD-10 Diagnosis Codes:
Admission Date:	Admission Type:
Discharge Date:	Discharge Diagnosis:
Discharge Status:	

ADDITIONAL NOTES: